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MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations
NC Association of County DSS Directors

FROM: Mark Benton

Mike Moseley

SUBJECT: Implementation Update #32: Accessing Care and Other Topics

Since the implementation of the new enhanced services on March 20, 2006, there have been many accomplishments including expanding access and serving more consumers. However, we have experienced a number of challenges as well. As a result of a recent review of data and utilization patterns of the new enhanced services, complaint investigations, onsite reviews and both positive and negative feedback from consumers, families, LMEs and providers, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance have jointly defined needed changes in the system. These changes take place on July 15, 2007.

These changes as defined in this update were communicated through training events entitled "Accessing Care" that were held at the following locations and dates: June 22 in Lumberton, June 26 in Durham, June 27 in Greenville, and June 28 in Hickory. An instructional video is being developed and will be placed on the DMH/DD/SAS web site in the near future for use by providers and LMEs in training current and new staff. All handouts referenced in the training events and on the video can be found at: http://www.ncdhhs.gov/mhddsas/training/index.htm.

This update covers the following topics of accessing care:

- Person-centered thinking.
- The revised flowchart for accessing care.

- The role of STR.
- STR referral for emergent services.
- STR referral for urgent and routine services.
- The person-centered planning process, forms and instructions.
- The role of assessment in the development of a person-centered plan.
- Service authorization.
- Minimum requirements for compliance for payment.
- EPSDT.
- Recommendations to providers.

Person-Centered Thinking

Person-centered thinking is the foundation of the transformed system of mental health, developmental disabilities and substance abuse services. Everything depends on the quality of thinking. A person-centered thinking environment fosters good ideas and actions, and as a result people lives flourish. The challenge is to put this into practice every day within every interaction in supporting all individuals.

Person-centered thinking is a set of promises:

- A promise to listen to what is being said and to what is meant by what is being said, and a promise to keep listening.
- A promise to act on what we hear by always finding something that we can do today or tomorrow, and a promise to keep on acting on what we hear.
- A promise to be honest and clear, and to let people know when what they want will take time to accomplish, or when we do not know how to help them get what they are asking for. It is being honest when we cannot find a good balance between what is important to the person and what we believe is important for the person.

The people we serve must always be involved in every decision that is made. By truly believing that through incisive questions and the opportunity to be heard, the people we serve often share their ideas and wisdom for making their lives better.

Person-centered thinking is essential as we move the basis of service provision to a more balanced framework between what is important "for" the person to what is important "to" the person To accomplish this, we have a tremendous amount of work to do to reduce the stigma surrounding persons with disabilities so that natural and community supports can occur for the individuals we all support

The Flowchart for Accessing Care

As a result of experiences during the first year of the enhanced services, the flowchart for accessing care was revised on June 20, 2007. While it looks similar to the first version, there are several changes that are explained in the following sections. You may find it helpful to review the attached **ACCESSING CARE: A Flow Chart for New Medicaid and New State Funded Consumers** as you read this implementation update. http://www.ncdhhs.gov/mhddsas/training/access-care/index.htm

The Role of Screening/Triage/Referral

Screening/triage/referral (STR) is one of a number of functions included in the DHHS-LME contract and that the LME performs on a 24/7/365 basis. STR can also be provided by a provider, but it is not a fee for service.

- STR begins with a person's initial contact with the LME or provider. STR is a brief process to quickly refer the person to the most appropriate service.
- The first function of STR is to screen the person for mental health or substance abuse problem or a developmental disability.
- For individuals eligible for Medicaid, STR is a conduit to a service provider who will assess the need for services. **STR does not determine medical necessity. STR may not deny access to services**. If a

provider who completes STR does not believe that they can meet the requested service needs, they are obligated to assist the consumer in identifying providers who may be able to serve them.

- The STR form and instructions and basic process have not changed. The staff of STR must obtain basic information about the person and use their best professional judgment to determine the severity of need – emergent, urgent or routine – as their initial responsibility.
- If the determination is made that the person's need is emergent, the referral to a crisis service should be made as soon as possible. The person should be seen within 2 hours. It is crucial that STR staff are well informed about all local and regional crisis services and the intent of those services. As required in legislation, LMEs are currently developing a full range of crisis services. The LME must keep STR staff informed about availability and capacity of the local and regional crisis services system. The LME must maintain an accurate current provider list to which STR can refer. See the section below regarding referrals for emergent services.
- For urgent or routine care, there are two types of referral. One is to a clinical home provider for comprehensive clinical assessment and service provision. The other is to a provider for outpatient services and/or a comprehensive clinical assessment. See the sections below regarding referrals for urgent or routine services.
- STR also identifies the person's financial eligibility.
    - For individuals eligible for state funded services, STR is the initial screening to see if the person appears to qualify as a member of a defined target population. If the person does not appear to meet the requirements for a target population, STR will refer the person to an appropriate community service.
- The STR staff identifies the most appropriate service and offer the person a choice of providers.

Clearly, the role of STR is significant. Staff must practice person-centered thinking as they listen and gather information about the person. They use their best professional judgment in referring the person to the most appropriate service, while offering choice. STR staff, either at the LME or the provider agency, must have the most current listing of providers within the local catchment area and be very knowledgeable of all the services to be able to make the appropriate referral.

STR Referral for Emergent Services

The initial goal of the STR process is to determine if the consumer is experiencing an emergent situation requiring an immediate response. The STR staff must use their best judgment to keep the consumer safe and secure. If the call is determined to be emergent in nature, the referral should be to a crisis provider for face to face response and evaluation within two hours of the initial call.

During the crisis service, information may be gathered for the comprehensive clinical assessment, but it is not expected that the person-centered plan will be completed during the crisis service. Information gathered for the clinical assessment will inform the qualified professional at the next level of care as to planning and ongoing assessments.

STR Referral for Urgent and Routine Services

As indicated above, there are two types of referral for urgent or routine services. One is to a clinical home provider for comprehensive clinical assessment and service provision. The other is to a provider for outpatient services and/or a comprehensive clinical assessment.

The definition of a "clinical home provider" and the identification of enhanced services that fit that definition has been clarified. A clinical home provider must be endorsed by the LME and enrolled by DMA to provide a service that has a qualified professional, develops the person-centered plan including the crisis plan, has the responsibility as a first responder (or identifies the first responder in the crisis plan), completes and submits appropriate forms to ValueOptions and/or the LME (such as the ITR, ORF2, the Consumer Admission Form, NC-TOPPS and/or NC-SNAP), and is responsible for assuring the completion of a comprehensive clinical assessment. In the case of children and youth, the clinical home provider is responsible for convening the Child and Family Team for the purposes of person-centered planning.

As shown on the attached flowchart, nine enhanced services may serve as a clinical home including: Intensive In-Home (IIH), Multisystemic Therapy (MST), Assertive Community Treatment Team (ACTT), Community Support Team (CST), Community Support–Adults or –Children/Adolescents (CS), Targeted Case Management (TCM), Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT).

Referral to a **Provider of Outpatient Services** may be chosen if the STR staff determines that a comprehensive clinical assessment is needed prior to determining an appropriate referral or for outpatient sessions if the situation does not appear to require long-term or intensive treatment.

- Persons who are eligible for Medicaid may receive a specified number of unmanaged outpatient visits (26 for children and 8 for adults) without prior authorization. Additional visits require prior authorization. Medication Management (code 90862) visits do not count toward the 8/26 visits. However, documentation of goals and action plans and progress notes are still required for these visits per Medicaid guidelines.
- Persons eligible for State funded services may receive outpatient visits only after authorization by the LME.

If during the course of the outpatient process or the comprehensive clinical assessment, the need for an additional MH/DD/SA service is identified, a referral from the clinical home provider or the outpatient services provider can be made directly to the identified service.

The Person-Centered Planning Process, Form and Instruction Manual (Does not apply to the CAP-MR/DD Program)

To facilitate the process and timeliness of getting consumers into services we have changed the person-centered plan (PCP) process. The new process calls for submission of the PCP in two stages. The forms and instruction manual have changed accordingly and can be found on the Division's web site at: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm.

The first stage is the **Introductory Person-Centered Plan**. This plan is for an individual who is new to the system or who has been completely discharged with no services for 60 days. We have streamlined the process to facilitate its completion within the first visit or within the first eight hours of Community Support or Targeted Case Management provided by the qualified professional. Use of the Introductory PCP allows the provider to quickly gather the information needed to request authorization from the authorization agency. This Introductory PCP includes basic demographic information, the action plan and goals, and a crisis prevention/crisis response page (emergency contacts, current medications, and advanced directives). The signature page is also included and constitutes the service order. The introductory PCP does not duplicate the information that is on the Inpatient Treatment Report (ITR). The introductory PCP is submitted to the LME and/or ValueOptions along with other appropriate forms (such as the ITR, ORF2, Consumer Admission Form, etc.) for authorization of services. As noted in Enhanced Services Implementation Update #17, V codes can be used as diagnosis codes to facilitate billing. See: http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm.

The second stage is the **Complete Person-Centered Plan** that is developed prior to the end of the first authorization period of the services requested and authorized. Each part of the Complete PCP requires person-centered thinking. Also during this time, the comprehensive clinical assessment must be completed to inform and shape the Complete PCP and determine the medical necessity of additional services requested. Within a specified number of days (see the section below on timelines and requirements for prior authorization), the Complete PCP along with other documentation must be submitted to ValueOptions and/or the LME for prior authorization of additional service units/hours/days as determined to be medically necessary. A new service order is required when instituting a new service or at the annual review of medical necessity.

The Plan Update/Revision must be completed:

- When an individual's needs change and a new service is requested.
- On or before assigned target dates.
- When there is a change in a service provider.

See the Division's web site for the PCP Instruction Manual that contains detailed directions and tips for completing both the Introductory and the Complete PCP: http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm.

For existing consumers on the current PCP format, they will need to be transferred onto the new Complete PCP either at the next revision or the annual medical necessity review. **All existing consumers must be on the new Complete PCP no later than June 30, 2008**

The Role of Assessment in the Development of a Person-Centered Plan

A comprehensive clinical assessment is a required process to provide diagnostic and other information needed for the person-centered plan. The assessment can be one particular assessment or a combination of assessments that are chosen to inform the provider about a particular individual. The kind of assessment chosen determines who can conduct it. The clinician uses the assessment results to make recommendations for the best treatment strategies or interventions to meet the person's needs. The individual's goals on the PCP and the comprehensive clinical assessment fit together. Providers must be familiar with core rules and the concepts of assessment and diagnosis.

A major change allows the use of various assessments to meet this requirement. **A Diagnostic Assessment is no longer the only choice for Medicaid eligible consumers completing a comprehensive clinical assessment.** Instead, there are a variety of choices including the following categories and codes.

- Diagnostic Assessment (T1023)
- Evaluation/Intake (90801, 90802)
- Assessment (H0001, H0031)
- Psychological Testing (96101, 96110, 96111, 96116, 96118)
- Evaluation & Management (E/M codes)
- State Substance Abuse Assessment (YP830, YP836)

Note that this list does not include all possibilities. See recent Medicaid bulletins for information about various assessment codes.

Service Authorization

Authorization is required prior to service delivery by ValueOptions for consumers eligible for Medicaid or by the LME for state funded services.[1] The only exception to this is for the clinical home providers of Targeted Case Management or Community Support for Children/Adolescents or for Adults. In this exception, a person is entitled to a maximum of eight (8) hours of unmanaged care for Medicaid only if they are new to the MH/DD/SA services system.[2] This initial authorization of 8 hours occurs once in a lifetime. Prior authorization is required for additional hours. See Enhanced Services Implementation Update #27 regarding this change that became effective on June 11, 2007, on the web: http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/index.htm.

Important Note: The current 8 hours unmanaged for Community Support is under active legislative review. Further communication will be forth coming.

ValueOptions handles all authorizations for Medicaid and NC Health Choice. Changes in authorization timelines and required documentation for direct admit services and for non-direct admit services can also be found on the web by clicking on Accessing Care Training at: http://www.ncdhhs.gov/mhddsas/training/index.htm. Provider relations staff is available at ValueOptions for Medicaid and for NC Health Choice to assist providers with specific questions.

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[1] If a person is eligible for State funded services only, they must also qualify for a target population as required in legislation.

[2] Note that "unmanaged" means that prior authorization is not required.

Currently, authorization requests are submitted to ValueOptions by FAX or by mail. Remember to keep fax confirmation sheets in case of a dispute. Forms and instructions are available in PDF or Word format for downloading and printing at the ValueOptions web at: http://www.valueoptions.com. It is anticipated that in the near future authorization forms can be completed online.

Crisis services must be authorized on the first day the services are provided either from ValueOptions or the LME to determine the medical necessity for the service provided. The authorization will determine the intensity and length of service approved prior to the next authorization period. Fax requests for authorization by ValueOptions for crisis services to 919-461-9645.

Minimum Requirements for Compliance for Payment

Per their Medicaid contract, providers have accepted the responsibilities for understanding the definition of each service they are enrolled to deliver and for being accountable for the funds received. This means that staff is fully trained on the goals and objectives of the service and the strategies and techniques used at a macro level. Furthermore, they know how to apply these to the individual needs of the consumers. They are responsible for making sure that consumers and families understand the purpose of the service or services they are receiving and the consequences of their choices. Providers are also responsible for all data collection and documentation requirements as well.

Likewise, a provider's business staff must know that the requirements are met for appropriate documentation, forms, prior authorizations, staff qualifications, and other quality assurance functions. All documentation supports the legitimacy of the billing. Quality assurance is an ongoing process. Clinical reviews and supervision are critical to a quality provider system. It is also important to know the reasons for denials of payment, make corrections as appropriate, and then resubmit.

Early Periodic Screening Diagnostic and Treatment (EPSDT)

EPSDT is important for it promotes preventative health care by providing for early and regular medical and dental screenings and provides the medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening. EPSDT is defined by federal law to serve individuals under age 21. The limitations and requirements of EPSDT must be known by providers. The Division of Medical Assistance (DMA) will conduct many training events on EPSDT during the coming year.

Recommendations to Providers

- Check the DMH/DD/SAS web site regularly. This is the single most important source of information and provides links to needed information on the DMA web site
- Read the DMA Medicaid Bulletins that are posted to the DMA web site the first of each month.
- Check the DMA web site for news on EDS and ValueOptions
- Quality assurance is an ongoing process. Conduct self assessments and post payment reviews. You can pay back to Medicaid without penalty.

Billing For Provisional Licensed Providers beyond 6/30/07

The decision was made and announced in Implementation Bulletin #29 on May 21, 2007 to extend the period that agencies can bill for provisionally licensed provided (H-Code) outpatient services through June 30th, 2008. In the same bulletin, it was noted the billing guidelines would be announced at a later date.

Agency billing for services of provisionally licensed providers will still need to be processed through the LME. It should be noted that similar to last year, this is a billing process that the LME may chose to do on behalf of the provisionally licensed provider. The difference will be provisionally licensed provider's agency must develop a contract directly with the LME to do this billing for them during this additional year through June 30, 2008. The Division had been covering the cost of the provisional billing during the previous eighteen-month extension, this will no longer able available. The billing arrangement may be now developed directly between the provisionally licensed provider's agency for which they work and the willing LME on a fee for service basis. An independent provisionally licensed provider should contact their licensure or certification board prior to developing a contract with the LME. This will ensure compliance with each profession's Scope of Work.

At the end of June 30, 2008 extension, all providers must be directly enrolled with Medicaid in order to bill for services provided. Please see Implementation Bulletin #29 for additional details: http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm

For further clarification, please send questions you may have concerning this information to contactdmh@ncmail.net

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